Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NORTHEAST METHODIST HOSPITAL

Respondent Name
WAL MART ASSOCIATES INC

MFDR Tracking Number
M4-10-3806-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
APRIL 30, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "IC failed to pay per DWC Rule 134.404 Hospital Facility Fee Guideline. Per DWC Rule 134.404, claim pays @ 143% of Medicare allowable."

Amount in Dispute: $40,341.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated May 18, 2010:

- IMPLANTS CORRECTLY REIMBURSED PROVIDER INVOICE COST + 10% LIMITED TO $2000 MAXIMUM ADD-ON = $24562.71.
- DRG 459 CORRECTLY DENIED FOR PAYMENT.
- DRG 460 AGAIN CONFIRMED AS CORRECT DRG FOR THIS ADMISSION.
- CORRECT DRG REIMBURSEMENT FOR THIS ADMISSION WOULD BE THE CMS FACILITY SPECIFIC VALUE FOR DRG 460 ($22251.41) x 108% = $24031.52.

Response Submitted by: Claims Management Inc.

Respondent's Supplemental Position Summary Dated May 19, 2010: "Please see the attached 'Position Statement' dated May 18, 2010, adopted and incorporated herein by reference as if fully set forth at length, which supports the Respondent's rational to maintain reductions. No additional allowance is recommended at this time."

Response Submitted by: Hoffman Kelley

Respondent's Supplemental Position Summary Dated September 13, 2010: "Carrier did NOT pay fees inconsistent with the fee guidelines adopted by the Division & described by Subsection (d-1) and & by an informal or voluntary network that includes a specific fee schedule. Therefore, there is no contract copy to be provided."

Response Submitted by: Claims Management Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2009 through May 7, 2009	Inpatient Hospital Services	$40,341.71	$40,215.85

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 11-The recommended allowance for the supply was based on the attached invoice.
   - 13-An additional allowance has been recommended for implants/prosthetics.
   - W1-Workers compensation state fee schedule adjustment.
   - 285-Please refer to the NOTE above for a detailed explanation of the reduction.
   - 5101-Please refer to note above for a detailed explanation of the additional information needed to process your billing.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - 1014-The attached billing has been re-evaluated at the request of the provider based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - NOTE-Correction of DRG 459 to 460.
   - Provider submitted DRG 459, Spinal Fusion except Cervical w/MCC. However, submitted documentation does not completely support this DRG. IDC DX 584.9 acute renal failure is not documented. This dx is reportable for Diseases of Genitourinary System/Neprthirtis, Nephrotic Syndrome, & Nephrosis/unspecified acute renal failure, acute kidney injury (non traumatic). Documentation instead supports ICD-DX 997.5 Complication of Surgical & Medical Care, Urinary Complication, acute renal failure, specified as due to procedure. This is confirmed by discharge summary detail, as well as finding of normal renal ultrasound. In the absence of ICD-DX 584.9, with consideration of all other submitted DX & Procedure codes, the resultant DRG = 460 Spinal Fusion except Cervical w/o MCC…Correction of DRG 459 to 460.

Issues

1. Does the documentation support billing of Diagnosis Related Group (DRG) 459?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the hospitalization based upon the documentation does not support billing DRG 459.

   DRG 459-Spinal fusion except cervical with major complications and/or co-morbidities.

   The requestor listed as the secondary diagnosis 584.9-Acute renal failure, unspecified. Medicare classifies the diagnosis 584.9 as a major complication or co-morbidity. The respondent contends that the requestor failed to document acute renal failure and therefore is not due reimbursement for DRG 459.

   The Division reviewed the submitted medical records and finds that the requestor documented an abnormal Creatinine test in the lab report from 1.9 on May 5, 2009 to 0.5 on May 7, 2009. The requestor also noted less urine output on the Discharge Summary as "volume depletion". The claimant also underwent a renal ultrasound. Based upon these findings, the Division concludes that the requestor supported billing DRG 459.

2. 28 Texas Administrative Code §134.404(b)(3) states "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment

amounts and reimbursement for implantables."

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
  (A) 143 percent; unless
  (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

28 Texas Administrative Code §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

28 Texas Administrative Code §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

- Documentation found supports that the DRG assigned to the services in dispute is 459, and that the services were provided at Northeast Methodist Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $37,236.90. This amount multiplied by 108% results in an allowable of $40,215.85.
- The total cost for implantables is $24,562.71. The sum of the per-billed-item add-ons exceeds the $2000 allowed by rule; for that reason, the total allowable amount for implantables is $24,562.71 plus $2,000, which equals $26,562.71.

Therefore, the total allowable reimbursement for the services in dispute is $40,215.85 plus $26,562.71, which equals $66,778.56. The respondent issued payment in the amount of $26,562.71. Based upon the documentation submitted, additional reimbursement in the amount of $40,215.85 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $40,215.85 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Elizabeth Pickle, RHIA	04/24/2014
Signature	Medical Fee Dispute Resolution Officer	Date

	Martha Luévano	04/24/2014
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.